Department of HUMAN SERVICES

Health Home Learning Collaborative

Transitions in Care

May 17, 2021

Logistics

- Mute your line
- Do not put us on hold
- We expect attendance and engagement
- Type questions in the chat as you think of them and we will address them at the end.

This training is a collaborative effort between the Managed Care Organizations and Iowa Medicaid Enterprise

Iowa Medicaid Enterprise
Pamela Lester
plester@dhs.state.ia.us
LeAnn Moskowitz
lmoskow@dhs.state.ia.us

Amerigroup
Sara Hackbart
sara.hackbart@amerigroup.com
David Klinkenborg
david.klinkenborg@amerigroup.com
Emma Badgley
emma.badgley@amerigroup.com

Iowa Total Care
Bill Ocker IHH
Bill.J.Ocker@IowaTotalCare.com
Tori Reicherts
Tori.Reicherts@IowaTotalCare.com

AGENDA

Introductions

Learning Objectives

Types of Transitions of Care

Discharge Planning

Transition Planning

Questions

Learning Objectives

- Identify the Member's suitability for transition
- Illustrate process of transitioning the Member into the most appropriate setting
- Outline means for providing support throughout and after the transition

Transitioning & the Health Plan

Provide the most integrated, least restrictive, and safest desirable living environment allowing the Member to achieve maximum independence

Types of Transitions

Hospital Admission

- If Member was in Community:
  - Inform Providers
  - Complete CIR
  - Discuss discharge plan

- If Member was in a Nursing Facility:
  - Contact MCO CBCM
  - Determine the bed level

Hospital Discharge

Returning Home vs. Transitioning into Facility Living

Hospital Discharge Planning

- Review member needs
- Where is member going?
- What support or resources are needed?

- Work with member's support
- Coordinate and establish new services
- Contact providers to initiate services

- Member is discharged
- Follow-up with member

Facility Transitions

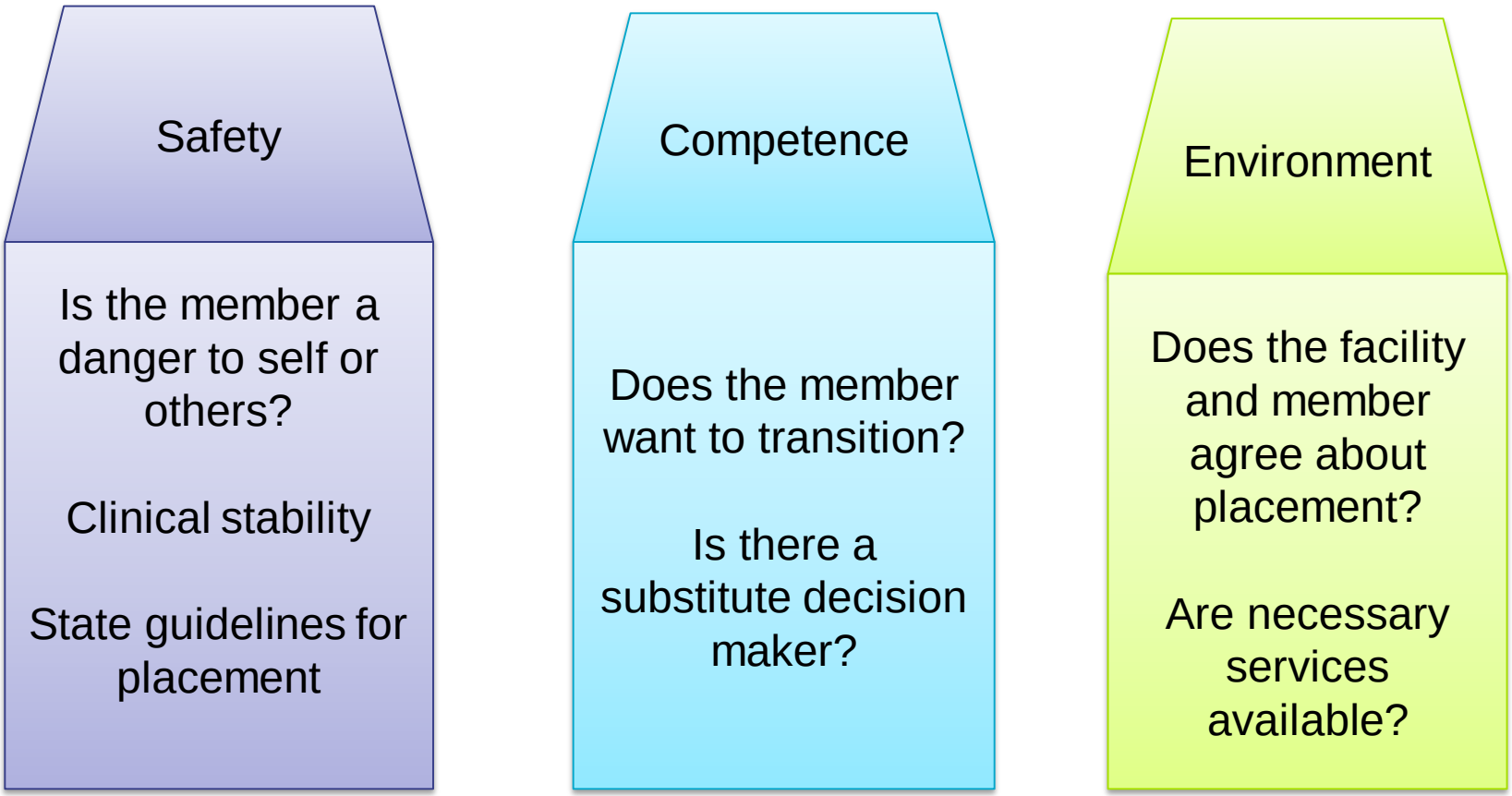
❶ Level of care available in alternate setting

❷ Minimal risk for readmission

❸ Expressed interest and consent

Transitioning from a Facility

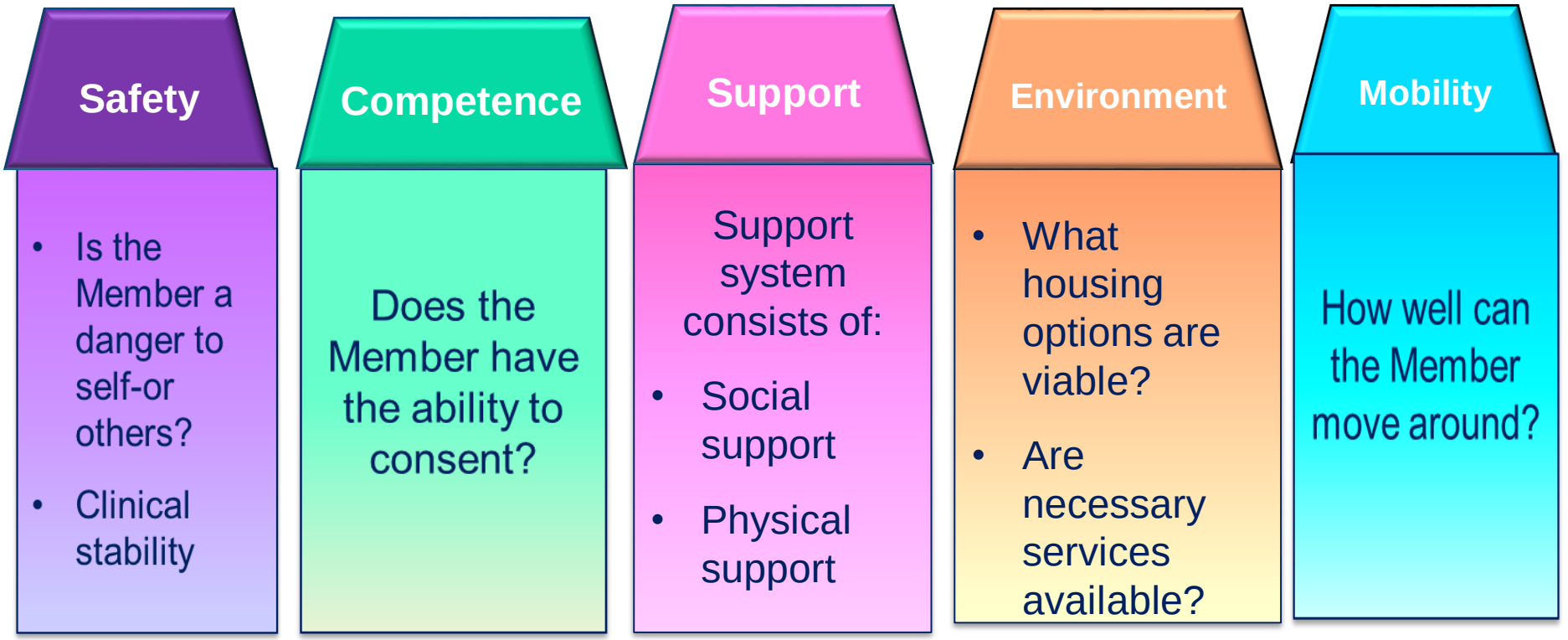
Transitioning into Another Facility



Identify Suitability

- Coordinate arrangements for transition:
  - Needs
  - Mental capacity
  - Identify level of care required
- Review Process
- Find available housing
  - Isolate housing option
  - Availability and barriers

Transitioning into Home or HCBS Setting



Transitioning from Jail

- Partner with diversion programs
- Online Tools
  - Iowa Courts Online
    - Some Juvenile Records are here
  - Department of Corrections
    - Search Status

HH to HH Transfer

Original Health Home

- Schedule a warm transfer meeting with the new health home, member, provider(s), etc.
- Provide the new health home with:
  - Current PCSP/PCCP
  - Current CASH
  - Other important documents
  - Date you will discharge member

New Health Home

- Participate in the warm transfer meeting
- Review documentation provided by original health home
- Obtain necessary ROI's to complete intake paperwork
- Update PCSP/PCCP and CASH within 30 days of enrollment to HH

DISCHARGE PLANNING

Discharge Team Meeting

- **Purpose**
  - Discuss best options for transition/discharge
  - Determine Member's ability to transition into applicable setting
  - Set up services needed
  - Modify/develop a PSCP
  - Should begin at the date of admission

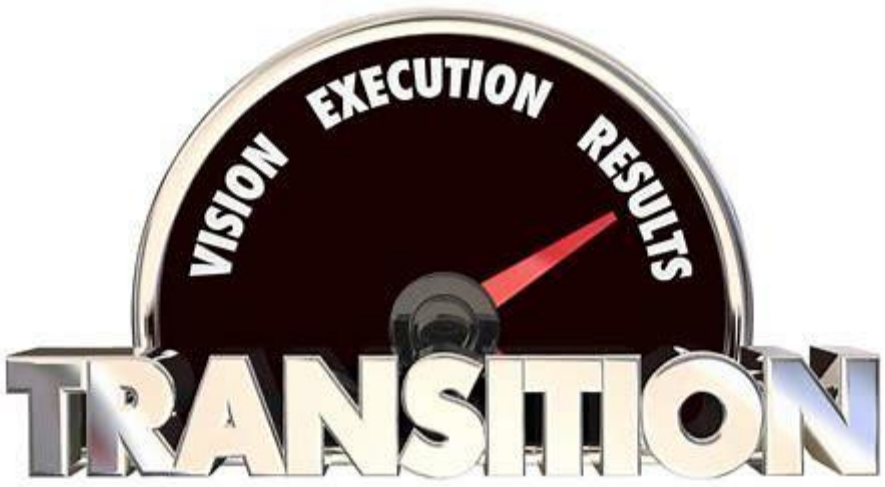
- **Discharge Team**
  - Member
  - Health Home RN/Care Coordinator
  - Support system (Family, guardians, providers, etc.)

Reminder – when a member is in the hospital or facility it is important that discharge plans are discussed and developed upon admission.

Key Components in Transition Planning

- Successful transitioning planning involves
  - Member & family involvement
  - Utilize Person Centered Principles and Processes
  - Provide Choice and Quality of Life
  - Life Options & Alternatives
  - Provision of Adequate Services in Community Settings

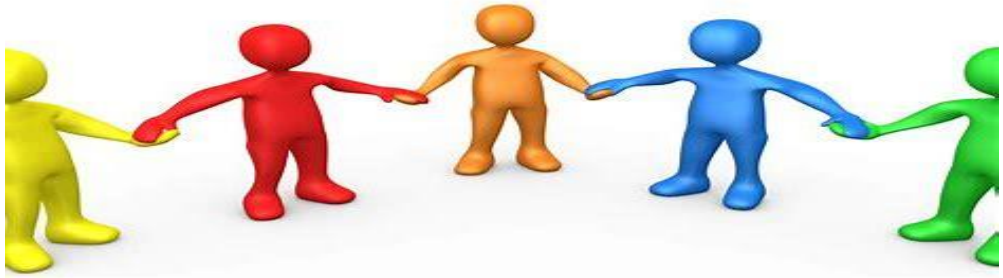
Transition Planning



Transition – How to Support

Transition Support

- Remain calm
- Listen to what they are saying
- Meet them where they are at
- Identify things you can do to easy their fears
- Focus on the members strengths



Key Elements of Successful Transition Planning

- Involves member, legal representatives & others of member choosing
- Follow person centered principles and processes
- Allows for expression of choice and quality of life
- Life options and alternatives
- Provides adequate services in community setting

Transition Plan Consists of

A document to provide communication to the entire team should consist of at least:

- Date/Time of Move
- New Address
- Main Point of Contact
- Who will help prepare
- Items to purchase
- Support for the member
- Community Resources
- Personal Belongings
- Transportation
- Medications
- Adaptive Equipment
- Medical Equipment
- Medical Appointments
- Back up Plans
- Safety/Crisis Plan

Preparing for Transition

A team meeting is important to hold to finalize the move and develop/modify the PCSP

PCSP/PCCP will need to identify

- New Address/phone #
- New Providers
- Risks – any newly identified
- Changes in safety/crisis plan
- Back-up plans to services
- Goals

Person Centered Service Plan

Strengths

Goals & Desired Outcomes

Recreation/Social Activities

HCBS Services

Financial/Budgeting

Education/ Vocational/Employment

Housing

Transportation

Mental & Physical Health Needs/Supports

- Needs/Diagnosis
- Treatment Options/Availability
- Therapies/Treatments
- Physicians/Specialist
- Medications/Management

Sociological Needs

- Natural Supports
- Friends/family
- Church/Faith

After Transition

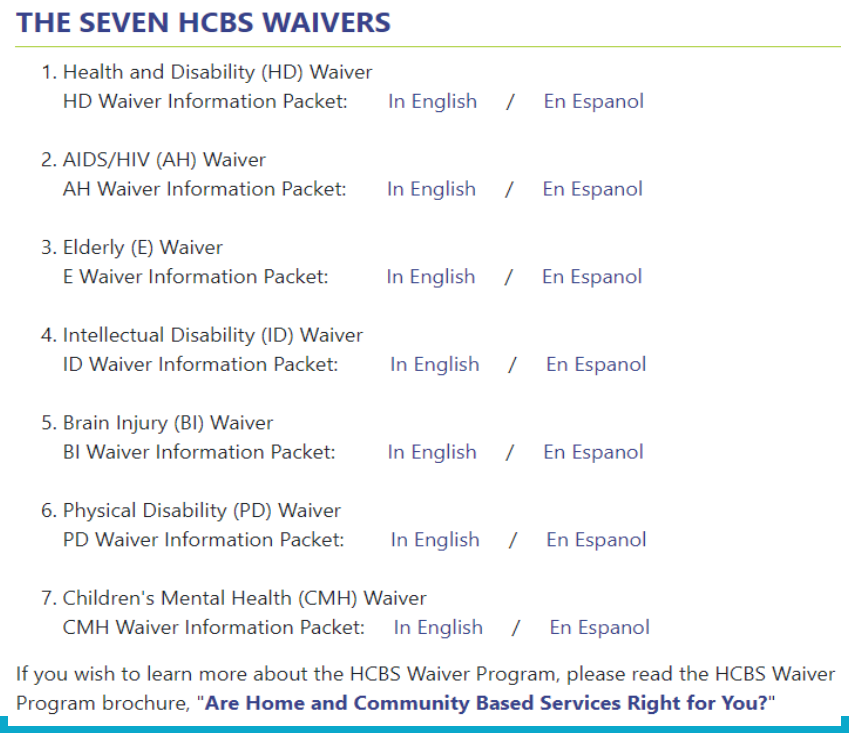
- Contact member w/in 5 days of transition
- Contact provider w/in 5 days of transition
- Follow-up with legal representative w/in 30 days
- 30 – 45 days after transition team meeting
- Continue meeting as needed for follow-up

Resources

- Referral tracker – spreadsheet attached to tracker referrals made and results
- How to Request Waiver when Member leaves Facility – document to step out process depending on discharge date
- Transition Guidebook – attachment
- Waiver Application for those currently on Medicaid

Resources

- Waiver Information Packets – https://dhs.iowa.gov/ime/members/Medicaid-a-to-z/hcbs/waivers



THE SEVEN HCBS WAIVERS

1. Health and Disability (HD) Waiver
   HD Waiver Information Packet: In English / En Espanol

2. AIDS/HIV (AH) Waiver
   AH Waiver Information Packet: In English / En Espanol

3. Elderly (E) Waiver
   E Waiver Information Packet: In English / En Espanol

4. Intellectual Disability (ID) Waiver
   ID Waiver Information Packet: In English / En Espanol

5. Brain Injury (BI) Waiver
   BI Waiver Information Packet: In English / En Espanol

6. Physical Disability (PD) Waiver
   PD Waiver Information Packet: In English / En Espanol

7. Children's Mental Health (CMH) Waiver
   CMH Waiver Information Packet: In English / En Espanol

If you wish to learn more about the HCBS Waiver Program, please read the HCBS Waiver Program brochure, "**Are Home and Community Based Services Right for You?**"

Resources

- PMIC Article on how to support families when their child is hospitalized/inpatient https://childmind.org/article/bringing-child-home-psychiatric-hospitalization/

Questions

Thank you!